Memphis Center for Reproductive Health
Patient Demographic Form
ALL PATIENT INFORMATION IS CONFIDENTIAL **Please print clearly in black ink.**

Pt #__________
Date:__________
DOB:__________

Legal Name:______________________ Preferred Prefix ______ Age:________
Preferred Name:______________________
Address:____
(Full Street Address) (City) (County) (State) (Zip Code)
Patient Phone Number: (H):______________ (C)______________
MCRH can leave a message for patient at (Circle) Home Cell No Messages
With a person (name):______________________
Email Address:______________________
May we add you to our mailing list? (circle) Yes No Email Only
Occupation:______________ Social Security Number:______________

Do you have a Primary Care Physician: YES NO
If yes his/her name & phone number:
____

Do you have health insurance? YES NO
Name of company:______________
Name of Policy Holder:______________
SS# of Policy Holder:______________
Date of Birth of Policy Holder:______________
Member ID Number______________
Group Number______________

Emergency Contact Person:______________
Relationship to you:______________
Phone # (   )______________
Does this person know you are here for services? YES NO
Who is here with you today: ______________

Have you been a patient at MCRH in the past? YES NO
Year of last visit:__________

Has your medical history changed since last visit? Yes NO
If yes, please explain:
____
____
____

Partnership status: (circle one) Married Partnered Single Divorced Widowed Legal Domestic Partnershi
Highest grade completed (circle one) : 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17+
Gender (circle one): Male Female Transgender: F to M M to F Other:______________
Ethnicity (circle all that apply): African American American Indian Asian Caucasian Hispanic Other:__________

How did you hear about us? (circle all that apply)

1. I was a previous patient
2. White Pages
3. Yellow Pages
4. Family/Friend
5. MD/Health Facility
6. MCRH Postcard
7. Internet
   a. MCRH Website
   b. Google/Yahoo/etc
   C. other
8. 411/Info
9. Newspaper AD
10. Abortion hotline/NAF
11. Other:__________

According to Chapter 1200-8-13 "Standards for Ambulatory Surgical Treatment Centers" for the State of TN any adult or emancipated minor may execute an advance for directive health care.
Would you like to execute an advance directive for health care today? (Circle one) YES NO

Signature of Patient:______________________ **Date:**______________

(IF YOU ARE HERE FOR ABORTION SERVICES, PLEASE COMPLETE THE BACK OF THIS SHEET)

Memphis Center for Reproductive Health
MEDICAL HISTORY
ALL INFORMATION IS CONFIDENTIAL. PLEASE PRINT IN BLACK INK.

PT#________________
DATE:________________
DOB:________________

Legal Name: ____ Age: ______

Preferred Name: ____

Primary Reason for Visit: ____________________________________

Past Medical History:

ALLERGIES

YES	NO	
☐	☐	LATEX
☐	☐	TETRACYCLINE/DOXYCYCLINE
☐	☐	ASPRIN
☐	☐	NOVACAINE/LIDOCAINE
☐	☐	IODINE/SHELLFISH
☐	☐	Do you have allergies to any other drug? If **YES**, list: ________________
☐	☐	Are you taking any medications (including vitamins or herbal medications):

____
____
____

YES	NO	
☐	☐	Are you taking any unprescribed drugs or medications? If **YES**, list:

____
____
____

YES	NO	
☐	☐	Are you currently breast feeding?

YES	NO	
☐	☐	Do you smoke? # per day _____ How many years ________
☐	☐	Would you like a referral for smoking cessation?
☐	☐	Do you drink alcohol? If yes: How often do you drink more than 2 drinks: Daily Weekly Monthly
☐	☐	Do you or your partner use injection medications or drugs?
☐	☐	Are you experiencing any neglect, violence or abuse?
☐	☐	Do you have any dietary concerns today? If Yes: ________________
☐	☐	Do you you exercise regularly? ________ X per week Type of exercise: ____________
☐	☐	Do you drink caffeine? ________ cups per day
☐	☐	Do you need a referral today? FOR:________________
☐	☐	Do you have children?
☐	☐	Major surgery or car accident (not childbirth)

GENERAL MEDICAL HISTORY

Have YOU ever had:

YES	NO	
☐	☐	diabetes (gestational or other)
☐	☐	cancer (type: ________________)
☐	☐	thyroid disease
☐	☐	sickle cell trait or disease
☐	☐	heart murmur / mitral valve prolapse
☐	☐	heart attack, heart problem or chest pain
☐	☐	asthma or breathing problems
☐	☐	blurred or double vision
☐	☐	anemia
☐	☐	high blood pressure
☐	☐	numbness in arms or legs
☐	☐	blood clots in arms, legs or lungs
☐	☐	redness, pain or swelling in arms or legs
☐	☐	emotional problems (i.e. depression)
☐	☐	tuberculosis
☐	☐	liver problems or hepatitis
☐	☐	kidney or bladder problem
☐	☐	stomach problems
☐	☐	gall bladder problems
☐	☐	seizure disorder or epilepsy
☐	☐	genetic abnormality
☐	☐	MD diagnosed migraine headaches
☐	☐	frequent or severe headaches

LIST ANY SURGERIES	YEAR
________________	______
________________	______
________________	______

LIST ANY HOSPITALIZATIONS (not childbirth) REASONS	YEAR
________________	______
________________	______
________________	______

FAMILY HISTORY

Have your ***PARENTS, BROTHERS, OR SISTERS HAD:***

YES	NO	
☐	☐	cancer (type: ________________)
☐	☐	diabetes (insulin or diet controlled)
☐	☐	tuberculosis
☐	☐	sickle cell trait or disease
☐	☐	death from a heart attack before age 50
☐	☐	epilepsy
☐	☐	thyroid problems

HAVE YOU EVER BEEN DIAGNOSED WITH THE FOLLOWING:

YES	NO		
☐	☐	Genital Warts (HPV)	________ year
☐	☐	Herpes (HSV)	________ year
☐	☐	Gonorrhea	________ year
☐	☐	Chlamydia	________ year
☐	☐	Syphillis	________ year
☐	☐	Pelvic Inflammatory Disease (PID)	________ year
☐	☐	HIV / AIDS	________ year
☐	☐	Have you been tested for HIV before	________ year
☐	☐	Partner with infection or symptoms ________	

____

____

____

PREGNANCY PREVENTION

YES	NO	Have you or your partner ever used:
☐	☐	condoms
☐	☐	spermicides
☐	☐	vasectomy
☐	☐	withdrawal
☐	☐	cervical cap
☐	☐	diaphragm
☐	☐	natural family planning
☐	☐	birth control pills (type: ______________)
☐	☐	Depo Provera shots
☐	☐	Nuvaring (vaginal ring)
☐	☐	Ortho Evra (patch)
☐	☐	Norplant / Implanon
☐	☐	IUD (Intra-uterine Device)
☐	☐	tubal ligation
☐	☐	problems with any method?

If "yes" explain:______________________

____

YES	NO	
☐	☐	Were you using a method when you or your partner became pregnant?

What method?__________________

Female Patients, Please complete this section:

How many times have you been pregnant? __________

How many pregnancies did you continue to full term(>37-40 weeks)? __________

How many pregnancies were premature? __________

How many abortions have you had? __________

How many miscarriages have you had? __________

How many living children do you have? __________

Year of Pregnancy	Type of Delivery	Weeks Pregnant

Any pregnancy complications?

☐ hypertension ☐ postpartum depression

☐ postpartum hemmorhage ☐ other

treated/how? ______________________

____

CDD Cost for a PAP Smear is $ 13.00

Menstrual History

When was the first day of your last period? ______________

YES	NO	
☐	☐	Was it a normal period? If **NO**, explain:__________________
☐	☐	Are you Currently Pregnant?

How often do your periods occur? Every _____ days

How long do your periods usually last? _____ days

How old were you when your periods began? ______ years old

☐	☐	Post menopausal

Form completed by: ☐ Patient ☐ Clinician ☐ Parent ☐ Patient Educator ☐ Other

YES	NO	
☐	☐	Are you currently taking HRT How Long? ____________________ What year was your last menses? ________
☐	☐	breast surgery, lump or other problem
☐	☐	tumor or fibroid in the uterus
☐	☐	abnormalities of the uterus
☐	☐	sores/bumps in genital area
☐	☐	vaginal itching/discharge/odor
☐	☐	pain or bleeding with sex
☐	☐	loss of interest in sex
☐	☐	Have you had a pelvic exam before?

Date of last pap smear ________________

Previous abnormal pap smear ___________

Signature of patient: ______________________________ Date: ______________

Clinician Signature: ______________________________ Date: ______________

Clinician Signature: ______________________________ Date: ______________